Report on the pre-opening inspection of

HMYOI Hindley

3–5 March 2009

by HM Inspectorate of Prisons

Published by:
HM Inspectorate of Prisons
1st Floor Ashley House
2 Monck Street
LONDON
SW1P 2BQ

Contents

Introduction

In December 2008, the Youth Justice Board (YJB) and the National Offender Management Service announced that, in order to focus better on the needs of their respective populations, Hindley and Lancaster Farms young offender institutions would cease being split sites for young people under 18 and those aged 18 to 21. Instead, Lancaster Farms would become a dedicated facility for those aged 18 to 21 and Hindley would be dedicated to those under 18. Indeed, with an operational capacity of 440 young people, Hindley would become the largest dedicated juvenile facility in Europe.

As part of an innovative service level agreement with the YJB, this Inspectorate agreed to undertake an independent inspection of Hindley to assess its preparedness for the proposed re-role. The service level agreement deferred entirely to the independence of the Inspectorate and left the choice of methodology of the inspection to the discretion of the Chief Inspector.

As neither building work nor the re-role were complete by the time of the inspection, we explored Hindley's preparedness essentially by assessing its revised policies and procedures against our independent criteria, *Juvenile Expectations.* In particular, we were concerned to assess how far the proposed policies and procedures appeared to mitigate the many risks that such a large juvenile establishment will face as it seeks to address the numerous needs and vulnerabilities of the young people in its care.

Our conclusions cannot be anything other than supposition. For example, it is impossible to predict how well these revised policies will be implemented or indeed whether other factors may intervene to hamper the re-role. Nor will the theoretical assessments in this inspection fetter our ability to criticise what we find when we return once the re-role is complete and our full outcome-based methodology is deployed.

Nevertheless, we were impressed by the clear vision of managers, their energy and their attempts to engage the whole staff group in the work required to successfully deliver the new Hindley. Most revised policies showed promise and had an appropriately child-centred approach. However, policies are merely a starting point. Success will depend on managers' ability to ensure a properly trained and committed staff, who are carefully supervised to implement effectively the new policy aspirations. We will return in October to assess the reality of the new Hindley.

Anne Owers — June 2009
HM Chief Inspector of Prisons

Section 1: Background to the re-role

1.1 The National Offender Management Service (NOMS) reviewed the provision of Prison Service accommodation for children and young people under the age of 18 and young adults in the northwest region at the beginning of 2008 following a series of problems at HMYOI Lancaster Farms. A report was produced in May 2008 recommending a move away from the current combined site arrangements at HMYOI Hindley and HMYOI Lancaster Farms where children and young people (under 18 years old) and young adults (18–21 year olds) were held in separate accommodation on both sites. Thereafter, NOMS recommended to the Youth Justice Board for England and Wales (YJB) the creation of a single dedicated site for young people under the age of 18 at Hindley and the re-role of Lancaster Farms as a single site for young adults. This recommendation was supported and accepted by the YJB and plans to re-role both sites were formally announced by the YJB and NOMS in December 2008.

1.2 The YJB and NOMS asserted that these changes would provide both age groups with better access to age-appropriate services and facilities, with staff specifically trained and committed to working with the different populations in a discrete environment. It was considered that, among other benefits, the new arrangement would enable the establishments to develop specific regimes to reflect the needs of their discrete populations to maximise resettlement opportunities, reduce reoffending, and improve safeguarding arrangements. The proposed changes reflected the key principles in the YJB's Strategy for the Secure Estate for Children and Young People and the Home Office's Youth Crime Action Plan. A programme of capital works was agreed at the two establishments to develop the physical environment of the sites to deliver improvements to the regime for the new populations. Furthermore, a staff training and development programme was proposed for development by the establishments to identify and address staff training needs.

1.3 A governance structure of joint YJB and NOMS and establishment project boards was put in place to manage the project and a transition plan outlined how the movement of the children and young people under 18 from Lancaster Farms and young adults from Hindley would start at the beginning of 2009 and be completed by 31 March 2009.

1.4 Prior to the re-role, Hindley had places for 192 children and young people under 18. Following the re-role, which was planned to start on 14 April 2009, the operational capacity for this age group was to increase to 440. An agreement between the establishment and the YJB's Placement and Casework Service had been reached initially to place 15 young people for the first four weeks and 30 young people per week thereafter, until the operational capacity was reached. Assuming the maximum number of young people were placed in accordance with the agreement, the transition would be complete by 22 June. It was further agreed that placement activity would be monitored to ensure a safe and sustainable build up of young people. This would be done, in part, by YJB performance monitors who were to remain on site for five days a week. The YJB gave a commitment to respond immediately to any concerns and slow down or stop the build up of places if required.

1.5 Hindley will be the largest young offender institution in Europe to hold children and young people under 18 years of age. There is a further proposal to increase the operational capacity even further in June 2010 to 483 using only single cell accommodation, or 515 using double cells.

Section 2: Methodology

2.1 The inspection involved the examination of the establishment's response to the service specification and related strategies, policies and procedures which had been newly developed, or existing strategies which had been modified to meet the requirements of the re-role. We did not examine existing policies which had not been revised which did not form part of the pre-opening preparations. However, all policies will be examined s part of the full post-opening inspection.

2.2 We interviewed senior managers who had been involved in policy revision, procedural changes or new developments specifically for the transition arrangements to ascertain:

- whether the planned changes were grounded in comprehensive and sound strategies which were understood and owned by functional heads or managers responsible for their implementation
- the extent to which there had been multidisciplinary engagement across the establishment, involving key stakeholders – including external partners, staff and young people.

2.3 There were obvious limitations and constraints on our usual approach to inspection which focuses on outcomes for children and young people and uses the four tests of a healthy prison – safety, respect, purposeful activity and resettlement – to make formal assessments.

2.4 Our standard inspection methodology involves staff interviews and examination of written policies and procedures, and to that extent we followed standard inspection practice. Triangulation of our evidence usually involves case sampling, observation of procedures in operation and speaking to young people about their perceptions and experiences to see whether policies and procedures are being implemented as intended. In the absence of opportunities to carry out that robust triangulation of evidence (since the transition had not taken place), we were unable to assess outcomes for young people.

2.5 We therefore chose to focus on the risks and mitigation of the risks associated with the significant increase in the size of the population and the creation of such a large establishment holding children and young people.

2.6 The risks that we considered were:

- simply warehousing children and young people, giving them far less individual attention
- creating an environment where the most vulnerable become overlooked
- that overall safety becomes compromised.

2.7 We focused on specific areas where we expected new policies or revisions to existing policies to have been made in an effort to mitigate the risks:

- early days in custody
- residential units and individual care
- safeguarding and behaviour management
- education and vocational training
- healthcare
- resettlement.

Section 3: Early days in custody – reception, first night and induction

Mitigating the risks

3.1 The reception facility was being refurbished at the time of the inspection. Future staffing arrangements had been agreed. The reception facility would no longer include holding rooms, as it was planned that the reception process would involve little more than checking basic information such as warrants.

3.2 A permanent staff group of nine suitably trained officers would be available during the day to act as reception officers and first night staff so that young people could be dealt with in reception as soon as they arrived. They would be taken across to the first night centre by a member of the first night team for all other procedures and assessments to be carried out.

3.3 The new build included a dedicated first night centre with 30 cells. The first night centre had not been completed at the time of the inspection, although the capital works programme had prioritised the completion of this facility. There were three private interview rooms on the first night centre and, with the number of staff available, resources were adequate to ensure that initial interviews and assessments were completed and immediate needs identified without delay. All new arrivals would be offered a shower as soon as they arrived on the first night unit and a telephone call, regardless of the time of arrival.

3.4 The procedures for the dedicated first night unit included the development of initial individual care plans for every young person, incorporating a range of early assessments, which would be passed to their allocated residential unit as they moved across on completion of their induction. This practice, if implemented well, would exceed our expectations (the current standard is that the most problematic and/or vulnerable young people will have individual care plans).

3.5 Ten of the 30 cells on the first night unit were to be used for 10 permanent peer supporters who would remain on the unit to support new arrivals on the first night unit during their first 48 hours. The model was innovative and the training package was impressive.

3.6 The establishment's senior social worker had been involved in the development of the first night procedures to ensure that young people who were looked after by their local authority were quickly identified and the necessary systems put in place to ensure that their specific needs were met, including arrangement of statutory looked-after children reviews.

3.7 The induction programme was timetabled to start the day after the young person's arrival. Induction was a two part programme and the first 48 hours were to be spent on the first night centre. The morning following arrival was to be taken up by a series of health screenings (see paragraph 7.8) and in the afternoon new arrivals would sign compacts, meet a member of the chaplaincy team and complete their PE induction. On the second day, the programme comprised a series of appointments with specialist staff, including their allocated caseworker, a social worker and a member of the advocacy service.

3.8 New arrivals would move to their allocated residential unit after 48 hours and complete the remainder of the two-week induction programme in classroom-based presentations, which also included education assessments. We were told that, should there be a cancellation of a

3.9 We were assured that young people would be fully occupied during the induction programme. The scheduled programme was divided into hourly sessions with no gaps other than for breaks and, if implemented as planned, would provide full and active days.

Remaining concerns

3.10 Procedures for the development of individual care plans for young people following completion of their induction were not finalised. There was a discharge checklist which required staff to record 'any outstanding issues' needing further development, but it was not a pro forma for a comprehensive care plan.

3.11 It was unclear how it would be ensured that care plans were multidisciplinary, incorporated all necessary assessments, with clear individual staff accountability for implementing various components of the plan.

3.12 The aim to produce individual care plans for all young people was commendable, but ambitious, and robust quality assurance procedures would be needed to ensure that the quality of the care plans was not compromised in an effort to produce something for every young person, regardless of their level of need.

3.13 If implemented as planned, the peer support programme would benefit new arrivals and the young people who would be trained in useful skills to carry out their role. Consideration should be given to accreditation of the peer support training.

3.14 It would be important to provide good quality support and supervision for the peer supporters located on the first night centre. We were told that the chaplaincy would support the scheme, but this had not been formalised. It was not clear how regular support and supervision of the peer supporters would be ensured.

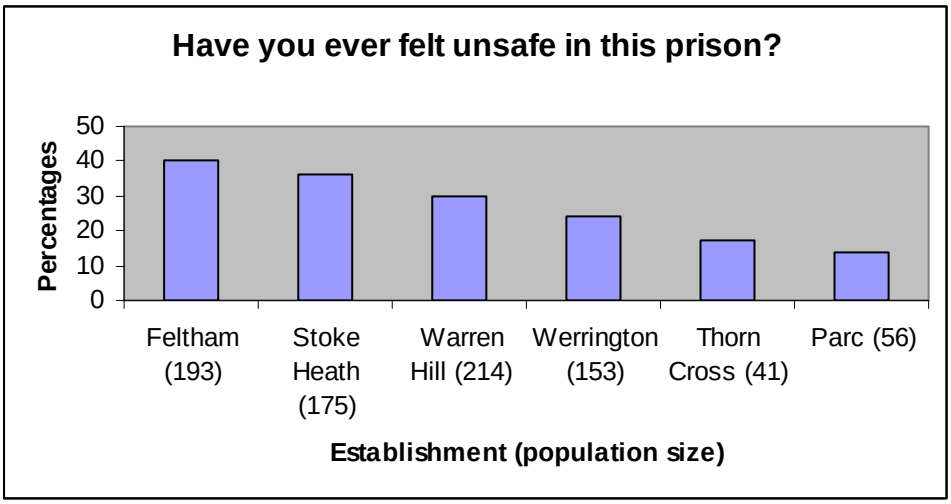
Section 4: Residential units and individual care

4.1 We have been repeatedly critical of establishments holding troubled and troublesome children and young people in numbers too large to manage safely.

4.2 In our thematic review of prison characteristics and their correlation with healthy prison assessments, we found that size was the most influential factor in how prisons performed against the tests of safety and respect, and overall. [1]

4.3 Specifically with regard to establishments holding children and young people under 18, we found that the size of the population was a strong predictor of an establishment having an overall healthy prison assessment score within the top 50%. Smaller establishments, holding 173 young people or under, were 24.5 times more likely to perform well.

4.4 Survey results also show that young people feel safer in smaller establishments.



Source: Annual Report 2007–08, HM Inspectorate of Prisons

Mitigating the risks

4.5 All managers interviewed acknowledged the difficulty of managing large numbers of children and young people safely and many of the new developments, policy revisions and procedural changes were based on what was described as an establishment dispersal policy, although it was not a written one.

4.6 The new build was to provide six residential units holding between 66 and 96 young people. However, building modifications had provided smaller, separate living and association areas so that young people would spend their time in groups of between 22 and 24 on the residential units.

[1] *The prison characteristics that predict prisons being assessed as performing 'well': A thematic review by HM Chief Inspector of Prisons*, January 2009

4.7 This meant that it had been possible to schedule association for all young people every evening and for the majority of the day at the weekend rather than apply the common arrangements in larger settings of split association or association on alternate evenings.

4.8 The ability to separate young people in smaller groups was considered by managers to be a potential advantage in the management of young people who needed separating from others, particularly for gang-related issues.

4.9 Salford Youth Service had previously been contracted to provide weekly youth work practice but this arrangement had expired. Future scheduled evening activities included an in-house youth club with places for 50 young people, divided into separate areas for music, arcade games and quiet activities. There were also 60 recreational gym places (including places on the astro-turf pitch) and enrichment activities on the residential units delivered by dedicated enrichment officers. An additional outdoor grassed association area was being built.

4.10 Only 12 of the 440 existing staff had expressed a wish to transfer to other establishments following the announcement of the change of function. New staffing profiles had been agreed and were due to be introduced on 29 March 2009. They were designed to provide dedicated residential staff groups, allowing a good level of continuity and individual care and the development of good relationships between staff and young people.

4.11 A mentoring scheme was being introduced for all new officers who had just completed their prison officer entry-level training and were working with children and young people for the first time. Experienced officers, who had been identified as needing additional support to adapt to working with young people, would also receive a mentor. The details of the scheme were set out in a new policy and the concept of formal peer support for staff looked promising.

4.12 The additional allocation of profiled personal officer time throughout the residential profiles, to enable them to maintain frequent contact with their allocated young people, attend important meetings relating to their care, and meet the requirement for weekly contact with families, accords with our expectations for personal officer work, but the policy had not been updated to reflect this.

4.13 The plans for Beech unit to become an under-16 unit accommodating up to 56 boys aged 15 years in small groups were at an early stage of development. The policy underpinning the work of the unit was still in draft and many areas needed further explanation and clarity. However, initial plans were encouraging and imaginative and thought had clearly been given to meeting the needs of this age group. Specific attention had been given to safety, care planning, educational needs, age-appropriate enrichment activities, consultation with staff and frequent family contact. As with the first night centre, there would be a dedicated staff group to assist in the development of good relationships and individual care on this unit. We were told that the YJB placement strategy acknowledged the additional vulnerability of this age group and, as a consequence, those placed would not be long distances from their home area.

4.14 Existing experience within the establishment of working with children and young people under the age of 18 was being utilised well and a good understanding of the different needs of this age group was evidenced in a number of areas. An example was the intention to monitor all security finds during strip searching on reception, with the procedures to be reviewed within six months. Many procedures included reminders to staff of the need to ensure that information was child friendly and to check that the young person had understood information that had been given.

Remaining concerns

4.15 We were given a copy of the core day as part of the response to the specification which scheduled half an hour for exercise on weekdays. This would not meet our expectation of one hour's exercise a day. We were assured during the inspection that we had been provided with an out-of-date copy of the core day.

4.16 The planned arrangements for dining out were too restricted and offered the young people opportunity to dine communally only for their evening meal. The lack of opportunity to dine out for all meals would be inconsistent with our expectations.

4.17 Proposed consultation with young people was not frequent enough and the notes of focus group meetings prior to the re-role did not specify the possible consequences for young people of the transition period and the re-role. Consultation with young people should be far more frequent and in smaller groups, so that more young people have the opportunity to comment on how they are looked after.

4.18 The existing personal officer policy was written in January 2008 and needed updating to reflect the functional change and the proposals to profile dedicated personal officer time. Personal officer practice as described in the existing policy would not meet our expectations which require a young person to be introduced to their personal officer and substitute officer within 24 hours of their arrival (the policy records that the introduction has to be within three days). The scheme was not sufficiently explicit about the regularity of formal contact with young people and there was no requirement, only encouragement, to attend key care planning meetings. However, there was an expectation that a written contribution would be sent. There was no mention of training for personal officer work. While the policy set out the different roles of caseworkers (see paragraph 8.2) and personal officers, it did not address in sufficient depth the need for good communication and coordination between the two different schemes so that the roles complemented rather than competed with each other.

4.19 There were some gaps in relevant training for staff who had not previously worked with children. Juvenile awareness staff programme (JASP) training for officers who had previously worked with young adults began in March and it was anticipated that 90 members of staff would be trained by 14 April 2009. This would mean that at the time of the first group of new arrivals entering the establishment, 10 of the 210 prison officers, seven of the 30 senior officers and two of the 10 principal officers would not have received JASP training. Arrangements had been made for those members of staff to be trained as soon as possible after 14 April. Decisions were still to be made about the requirement and priorities for other training. We were told that training in assessment, care in custody and teamwork (ACCT) procedures, race awareness and implementation of the rewards and sanctions scheme was also a priority for the establishment, but the training plan to deliver these courses had not been finalised.

4.20 While mentors of new staff were to be supported in their role by front line managers, specific training for this important role was not included in the implementation plan. The scheme would need rigorous monitoring and evaluation to ensure effectiveness and continuous improvement.

Section 5: Safeguarding and behaviour management

Mitigating the risks

5.1 The strategic objectives for the safeguarding department included the delivery of presentations to 22 local safeguarding children's boards from which the establishment would be receiving children. This had been agreed through the Wigan safeguarding children board (WSCB) secure settings sub-group, which met monthly at Hindley and was chaired by the head of safeguarding. WSCB had been regularly updated on the progress of the re-role through the sub-group meetings and the separate executive chairs' board meeting.

5.2 Considerable work had been undertaken to involve WSCB in joint discussions of safeguarding issues relating to the re-role. The newly appointed independent reviewing officer for looked-after children and the local authority designated officer with responsibility for investigating allegations of professional abuse had visited the establishment twice. A meeting had taken place with Wigan's Director of Children and Young People's Service to consider how best to support the enhanced social work service that would need to be developed.

5.3 A dedicated young person's support worker had been designated to work with looked-after young people during the transition to ensure that reviews continued to be carried out within required timescales and appropriate liaison with their local authority took place.

5.4 Safeguarding policy documents, including suicide and self-harm prevention and violence reduction, were being updated to reflect the change in the population, with completion and ratification by WSCB scheduled for 1 April 2009.

5.5 Training relating to safeguarding areas, including assessment, care in custody and teamwork (ACCT) refresher training and the juvenile awareness staff programme (JASP), had been prioritised for delivery during March, April and May. Although this meant that training would be continuing while the build up of the new population was taking place, staff who had not had previous experience with children and young people under 18 had been prioritised for training and the programme would be completed before the establishment reached capacity.

5.6 Criminal Records Bureau (CRB) checks were being carried out on all staff, including retrospective checks, and 480 requests for clearance had been despatched to the CRB. Twelve per cent remained outstanding at 5 March 2009.

5.7 There was a proposal to hold adjudications on the units and a stated intention to make behaviour management more age appropriate, which was positive.

5.8 There were plans to close the current care and separation unit and to manage and care for disruptive young people through individual care planning as part of the existing complex needs service. This would be consistent with our expectations concerning the management of challenging and vulnerable young people.

5.9 There was evidence of a good level of discussion about individual problematic young people as part of the existing complex needs meetings. Currently any member of staff could make a referral to the complex needs service via the safeguarding team if they had particular concerns about a young person. The complex needs meetings were chaired by the head of safeguarding

5.10 Currently the most problematic young people – who could be vulnerable or disruptive or both – were located on the Willow Unit and reviewed weekly at the complex needs meetings. The unit was staffed by discipline staff who had undergone specific training for their role as well as spending some time at the Gardener Unit – the national adolescent forensic inpatient unit. Young people in the unit had access to one-to-one support from a part-time clinical child psychologist who also supervised nursing staff and the officers who offered one-to-one support. All young people located on Willow Unit had an individual care plan developed jointly by nursing staff and discipline staff.

5.11 We were told that, following the re-role, the Willow Unit would provide care for the most disruptive young people and that there were plans for the mental health in-reach team to support residential staff and equip them with the skills necessary to manage vulnerable young people on the residential units. This would also meet the recommendation that we made following the last inspection which was critical of the use of healthcare in the management of both vulnerable and disruptive young people who did not have a clinical need.

5.12 We interviewed the consultant psychiatrist from the Gardener Unit, who spoke highly of the way that Willow Unit and the complex needs service operated, and was fully supportive of the proposals to manage vulnerable and disruptive young people following the re-role. She described the development of the Willow Unit as a vehicle for a sea change in approach by staff to the management of difficult and challenging young people, as well as a significant shift towards a more child-centred culture.

Remaining concerns

5.13 There was no policy to describe the role and function of the Willow Unit or how the unit and associated services would form part of the overarching behaviour management policy or safeguarding policy. There were no written procedures setting out referral criteria, how young people would be assessed and how care plans would be developed and reviewed. This was not consistent with our expectations relating to behaviour management or safeguarding, which require a clear strategy for the management of challenging and vulnerable young people.

5.14 Current throughput for the Willow Unit and the care and separation unit would suggest that the combined model will not provide sufficient capacity commensurate with the increase in the population. The unit would have an operational capacity of 13.There had been 41 admissions to the Willow Unit during the previous six months. The average length of stay was 23 days, but the longest stay by an individual during that period was 193 days. We were aware that projections for future use were predicated on a number of other changes regarding behaviour management, which suggested to us an even greater need for a clear strategy.

5.15 Capital works necessary for the planned development of the Willow Unit were not scheduled to begin until the end of April 2009 with an estimated completion date towards the end of October, which would necessitate the continued use of the care and separation unit. While we did not inspect the current arrangements in the care and separation unit as part of the pre-opening inspection, concerns were expressed following the previous inspection about the environment, the regime and lack of individual care plans, and so it was regrettable that it would continue to be used following the re-role.

5.16 In addition to the weekly complex needs meetings, there was a weekly safety and control meeting which monitored problematic young people whose behaviour was a threat to the safety of others rather than to themselves. There was obviously considerable overlap between the two meetings and there was a proposal to combine them. While this seemed sound in principle, we questioned the scope to manage the potential increase in workload and retain the focus on individual discussion of each area.

5.17 There were gaps in the current anti-social behaviour policy and behaviour management strategy which were still under review. The strategy included a proposal for 'unit managed regimes' which would assist the wider aim of closing the care and separation unit and managing unacceptable behaviour on the residential units whenever possible. This was commendable. However, criticisms made following the previous inspection regarding cool-down cells – because governance was inadequate and the use of separation on the units was not part of a wider behaviour management policy – would equally apply to the current unit managed regimes initiative.

5.18 The ongoing discussions concerning the funding of social worker posts in young offender institutions nationally had once again resulted in recent short-term agreements for 2009–10 by the Department of Children, Schools and Families. This had prevented the finalisation of the transfer of funding from Lancaster Farms and Thorn Cross to Hindley and the recruitment of the required number of social workers to meet the projected increase in demand for this service. In the meantime, there was insufficient capacity in the safeguarding department to ensure that statutory reviews for looked-after children were carried out.

Section 6: Education and vocational training

Mitigating the risks

6.1 A wide range of good quality education and vocational training will be essential to ensure that all young people are purposefully occupied for the majority of the day in activity that meets their individual needs and interests them, and to contribute to the provision of a safe regime.

6.2 The transition implementation plan covering the development of education and vocational training to meet the needs of the new population was regularly reviewed and updated. The plan provided a full-time programme of education, vocational training and physical education for 440 children and young people.

6.3 The revised curriculum included a very good range of vocational training provision, as workshops previously used by the young adult population would be available to the new population. However, there were not enough short accredited courses in all vocational areas to ensure that all young people had the opportunity to gain useful accreditation, regardless of the length of their sentence.

6.4 Liaison with Lancaster Farms had been effective and the transfer of information about individual young people who had transferred to Hindley had been good, although there had been insufficient information about previous achievements to ensure that young people were not repeating assessments unnecessarily or being allocated to courses they had already completed. Systems to ensure an effective flow of this information from other establishments, or from youth offending teams for young people arriving straight from court, still needed to be developed.

6.5 There were comprehensive plans to develop and improve induction linked to better individual needs assessments. There had been problems with security clearances in the past, restricting access to large parts of the curriculum for some young people, but this had been examined as part of the transition plan and the issues were being addressed.

6.6 Eight new posts had been created for officers to support young people in education. There had been a good deal of interest in the posts and appointments had been made following competitive interview. We observed the dedicated education officers interacting well with young people who were clearly comfortable approaching them for help.

Remaining concerns

6.7 At the time of the inspection, the timetable provided 30 hours of education, training and PE a week and 85% of young people were accessing this level of provision, with the remainder accessing approximately 27 hours, which was commendable. This was about to reduce to approximately 25 hours a week from the end of March 2009 following a re-profiling of all regime provision, including education and vocational training, to take account of the re-role.

6.8 The re-profiling exercise had taken place when there was much uncertainty nationally about future learning and skills funding arrangements for education and vocational training from the Learning and Skills Council (LSC). We were told by managers at Hindley that all their planning assumptions for the delivery of purposeful activity had been based on existing funding arrangements which enabled them to provide 25 hours' education and vocational training.

6.9 A subsequent decision was made that the LSC provider (Manchester College) would be funded by the YJB to deliver a minimum of 15 hours of learning and skills provision for each young person per week in the new Offender Learning and Skills contracts. In addition, Hindley was expected to provide 10 hours of constructive activity for each young person per week to maintain existing activity provision at 25 hours for all. While the consequences of this change in funding arrangements were not unique to Hindley, in the light of a major increase in the population, there were concerns that it would seriously affect the establishment's capacity to deliver the very broad and balanced curriculum currently available. In particular, the lack of a full and active purposeful day would seriously undermine dynamic security and had potential consequences for the safe management of such a large group of volatile and vulnerable young people.

6.10 The quantity of Connexions support was inadequate and there was uncertainty about the future role of the information, advice and guidance (IAG) workers when they transferred to Connexions in July 2009. The IAG workers played a valuable and proactive role in supporting young people who were refusing to attend education and it was unclear whether this support was sustainable in light of the pending changes.

6.11 The classroom which had been used for the self development course for vulnerable young people on Elm Unit was due to be taken out of commission. While we do not advocate separation of vulnerable young people, we were concerned that the transition plan did not include alternative provision or a strategy for managing vulnerable young people who were unwilling or unable to attend mainstream classes. In addition, the future funding for learning support assistants and the special educational needs coordinator (SENCO) posts was uncertain. The loss of these important posts would create significant difficulties for initial assessment and individual support for particularly vulnerable young people, as well as young people under school leaving age (USLAs) for whom the SENCO had operational responsibility. Although USLAs would have equal access to education and vocational training, there were no plans to ensure that their different and specific needs would be met.

6.12 Joint training had taken place for learning and skills staff with previous experience of working with juveniles and those who had previously worked with young adults. This had covered topics such as teaching, behaviour management and child protection. Most of the teachers had experience of teaching juveniles. All learning and skills staff had been CRB checked.

6.13 One of the biggest challenges presented by the increase in the population of juveniles related to the movement of greater numbers of young people from the residential wings to classrooms and vocational training workshops in areas at opposite ends of the prison. Some work had been carried out to identify the risks, but work was still needed to ensure timely and safe movement to activities.

Section 7: Healthcare

Mitigating the risks

7.1 Health services at Hindley worked closely with their commissioners to ensure the delivery of comprehensive services to meet the needs of the population. Staff we spoke to were confident that they had a staffing structure and policies in place to care for the increased numbers of juveniles, but were realistic in identifying that services might need to be altered to meet needs once the full complement of juveniles was resident.

Joint working

7.2 Health services at Hindley were commissioned by Ashton, Leigh and Wigan Community Healthcare Primary Care Trust (PCT) and were provided by the provider arm of the same PCT. Prison health was part of the children and young people's directorate of the Trust. It was evident from the minutes of meetings, the health needs assessment and discussions with both commissioners and providers of services, that the commissioners were closely involved in the provision of health services to the children and young people at Hindley. We found evidence of joint working and an awareness of the role of the PCT commissioners in improving the services provided. However, we were disappointed to note that this close collaborative working was not reflected in the response to service specification drawn up by senior managers in the prison.

7.3 The health needs assessment (HNA) had been completed in August 2008 with the re-role in mind. It was planned to repeat the HNA in October 2009 which would be six months after the establishment fully changed role. We considered this to be a sensible approach. There were a number of recommendations made in the HNA, all of which had either been achieved, were in the process of being worked through or had business cases drawn up for the required funding.

Clinical governance

7.4 It was pleasing to note that there were very few vacancies in the health services team. Some staff had only recently been recruited, but were clearly integrated into the existing team and had defined roles and responsibilities. For example, one of the band 6 nurses was the link for looked-after children and had regular contact with the looked-after children's community nurse. Some of the newly recruited staff were in post as a direct result of deficits noted in the HNA and successful bids for funding of the posts.

7.5 There was an ongoing assessment of training needs within the staff group. Staff were able to access continual professional development relevant to their roles and responsibilities and a range of in-house informal training was provided, such as sessions from the senior nurse at the local NHS walk-in centre and from the newly appointed clinical substance use nurse. Staff also had access to online training. We were told that in recent weeks training had been modified in preparation for the re-role to ensure that health services staff were confident of meeting the specific needs of 15–18 year olds. Clinical supervision was available and we saw documentary evidence that all staff received regular appraisals.

7.6 There was an electronic clinical information system which had been adapted to include the YJB initial template for all new receptions. A separate triage algorithm assessment had recently been introduced and was being adapted to meet the specific needs of the new

Primary care

7.7 Staff were confident that they could cope with the numbers of young people that Hindley would eventually hold. The staff we spoke to were aware that they would be caring for children.

7.8 Children were seen by a nurse on arrival and again the following day for a well person assessment. There were a number of other assessments carried out as part of the secondary screening, including mental health and substance misuse, and others were planned. Children were asked for their consent to share clinical information with other relevant parties.

7.9 All the relevant childhood vaccinations were provided as required. Two nurses took particular responsibility for the task and, as well as running specific clinics, would also visit individual units to run sessions. Vaccinations were administered under patient group directions (PGDs).

7.10 Health promotion and education were seen as central to the primary care offered and health services staff were pivotal to the prison induction programme that was planned. There was a full-time health improvement officer (band 7) who took the lead in all aspects of health promotion and education. She had completed the HNA and was involved in the redesigning of services to ensure they were child friendly. She had devised the health aspects of the induction programme, organised and run a bespoke parenting course with input from a number of outside agencies which had been evaluated by the Trust for the Study of Adolescence, provided ad hoc health education during association times and trained education staff in providing SHRE sessions. It was, therefore, disappointing to note that her contract was only for one year and, at the time of our visit, further funding had not been confirmed.

7.11 Smoking cessation services were provided on a one-to-one basis. Nicotine replacement patches were prescribed if required. There were plans to administer them using a PGD which was a sensible initiative.

7.12 GP sessions were provided by a temporary GP service as the service was out for tender. There were five surgeries a week and out-of-hours cover was provided by the local community service. None of the nurses was a nurse prescriber which would have enhanced the service they provided.

7.13 Visits to outside health services were well managed, in part because the prison had developed a good relationship with the local NHS walk-in centre, so young people could be escorted to the centre at a pre-agreed time if required.

7.14 There were three dentist sessions per week, complemented by two sessions with a dental hygienist and five sessions with a dental governance nurse. This was an increase over previous provision. There were good arrangements for out-of-hours emergency dental care.

7.15 One of the innovative posts that had been created was that of a full-time speech and language therapist. He took referrals from a variety of sources and saw all the young people admitted to the Willow Unit. He had plans to see and assess all new arrivals at the establishment, although realised that this might not be possible. He worked with the young people on a one-to-one basis over a period of at least 10 weeks. There was no absence cover provided for his post.

7.16 Another innovation was the appointment of two learning disabilities nurses to work as a discrete service. They had only been in post for four weeks when we visited and acknowledged that their service was in its infancy. They intended to develop a care pathway specifically for young people with a learning disability. They had made contact with community services and were clear how they would be working across the multidisciplinary team in the establishment.

Mental health

7.17 Mental health services were provided by Greater Manchester West Mental Health Foundation Trust (Child and Adolescent Directorate). There was a team of seven band 6 nurses, a band 7 team leader and a nurse specialist for complex needs (band 8a). The team also included a psychologist for two days a week as well as sessions from CAMHS psychiatrists, an art therapist and counsellors.

7.18 The team was confident that they provided all four tiers of a CAMHS service. There was a mental health day unit and a complex needs unit (Willow). The previous inpatient unit beds had been closed, although there were two beds in the unit that could be used for emergency health care admissions.

7.19 The psychologist only saw young people who were already known to the mental health nursing team. He provided support to the nurses in managing specific cases, but his limited time at the establishment and lack of absence cover did not allow him to have a specific caseload, which was regrettable.

7.20 The mental health team also provided a service to the Willow Unit which was managed by the safeguarding department (see paragraph 5.10).

Substance use

7.21 In preparation for the re-role of the establishment, the young people's substance misuse service (YPSMS) team had been disbanded and incorporated into the reducing reoffending team which was split into five further teams (see paragraph 8.2). Each team included a previous YPSMS caseworker. It was anticipated that all the key workers in the new team structure would be trained to the same standards as the ex-YPSMS workers using DANOS competencies (drug and alcohol occupational standards). The change in the organisational structure had apparently been introduced to avoid the previous duplication of assessments of young people.

7.22 The vast majority of young people with substance use issues currently at Hindley were users of alcohol rather than opiate-based illegal substances. The band 7 nurse was in the process of introducing local prescribing regimes for detoxification, although had no access to specialist prescribers at the time of our visit. She had also made links with local community services.

7.23 Some drugs and alcohol group work was undertaken in education as part of personal, social and health education.

Remaining concerns

7.24 There was a lack of nurses with a sick children's nurse registration (RSCN).

7.25 We were concerned to note that the prison would not allow two of the nurses to participate in any activity involving contact with prisoners because they were pregnant. This was despite the fact that their employer, the PCT, had risk assessed their work place and was satisfied that, with some provisos, direct contact with young people was possible. The prison's stance meant that the nurses were not able to use their clinical skills or contribute fully to the health services team. This was detrimental to the provision of services to young people.

7.26 One of the consequences of the development of a specialist multidisciplinary team was a lack of suitable space in the healthcare centre for each lead nurse. We were troubled to see specialists in effect carrying their work around with them because they had no permanent base.

7.27 It is to be hoped that further funding will become available to enable the continuation of the excellent health promotion work currently undertaken.

7.28 The changes to the structure of the YPSMS had resulted in some confusion for the newly appointed clinical substance misuse nurse, who was employed by the PCT. She was new in post and was unclear how her role would fit into the new structure. This required urgent clarification and a formal agreement for information sharing.

Section 8: Resettlement

8.1 A large multidisciplinary, multi-agency reducing reoffending team had been developed to cope with the challenges of ensuring that all young people from a wide and significantly increased catchment area would receive an appropriate level of individual attention to their resettlement needs.

8.2 The model provided a key worker/caseworker to all young people. Twenty two key workers/ caseworkers were split into five teams, managed by an appropriately qualified senior youth offending team practitioner and four multidisciplinary staff. Three of the teams were to be generic: one team holding smaller caseloads was intended to specialise in high risk cases, such as indeterminate sentences and young people subject to MAPPA (multi-agency public protection arrangements); another team was intended to manage the remand population. Average caseloads when the population reached 440 would be 18 young people for each key worker/caseworker and their workload included regular one-to-one sessions with all young people.

8.3 The building programme included a purpose-built facility to cope with the projected increase in demand for remand management and training planning meetings. The building work had started on 8 January 2009 and was due to be completed by April.

8.4 Consideration had been given to the management of gang-related issues in the establishment as part of the development of the reducing reoffending strategy. Funding had been secured to establish a full-time liaison officer to work with a full-time police intelligence unit. Separation of young people in the recent past had led to a considerable number of young people being refused access to certain activities. A decision had been made to manage any potential gang-related problems by dispersing young people throughout the newly created small units and creating wider and more equitable access to activities.

Remaining concerns

8.5 All the healthcare staff we spoke to were clear that part of their role was to refer young people in their care to relevant community services on release. Some commented that this was difficult when community provision for 15–18 year olds was poor, for example speech and language therapy. All commented on the variation in provision of YOT health workers. This had been recognised as an issue and the health improvement officer was arranging for YOT health workers in regular contact with prison health services staff to discuss with them ways of improving the services provided.

8.6 A reducing reoffending strategy was still in development. There had been no resettlement needs analysis, even though the response to the specification reported that an analysis had been undertaken. In our thematic review of prison characteristics and their correlation with healthy prison assessments, distance from home was the key variable in performance against resettlement. This was of particular relevance to women and young offenders. The lack of an up-to-date resettlement needs analysis in the light of the significantly different catchment area and much changed demographics was a weakness and, as a consequence, many of our expectations in relation to resettlement would not be met.

8.7 The previous contract which provided family links workers had not been renewed. There were plans for a dedicated social work post with responsibility for developing a new family strategy.

Section 9: Conclusions

9.1 There had been recent engagement with the whole staff group about the change in function/re-role as it would affect them. This was a good initiative, but it needed to continue as part of an establishment -wide post-opening communication strategy. We were told that there was a strategy, but details of implementation had yet to be agreed.

9.2 There was evidence of vision and apparently genuine enthusiasm from senior managers who would be responsible for delivery of new and amended policies. All functional heads had produced, and were regularly monitoring, a transition implementation plan relating to their area of responsibility.

9.3 Most establishments have appropriate policies in place to meet our expectations. However, they often fail to meet expectations when policies are not implemented as intended. Policy implementation at Hindley will be tested when we return for the full inspection in October 2009. Meanwhile, robust quality assurance systems need to be in place to ensure that new policies and procedures are understood and correctly implemented by all staff.

Appendix I : Inspection team

Fay Deadman	Team Leader
Ian Thomson	Inspector
Elizabeth Tysoe	Healthcare inspector
Martyn Rhowbotham	Ofsted inspector